PEAK MEDICAL GROUP

Ph: 1-833-738-PEAK (7325)
Fax: 1-855-738-PEAK (7325)
www.peakmedicalgroup.ca
info@peakmedicalgroup.ca

POST COVID-19 PULMONARY FUNCTION TESTING (PFT) REFERRAL FORM

PEAK MEDICAL SPECIALTY CENTRES | PEAK PULMONARY FUNCTION LABORATORIES | PEAK SLEEP CLINIC | PEAK OXYGEN | PEAK RESEARCH GROUP

PATIENT DEMOGRAPHICS (PLEASE PRINT OR AFFIX LABEL)

Last Name:_____ First Name:_____ PHN:_____

Date of Birth:_____ Sex: ☐ *M* ☐ *F* *Identify as:*_____ Phone Number:_____

Address:_____

POST COVID-19 QUICK REFERENCE TOOL

Patient was hospitalized (ie. admitted as an inpatient) for any length of time for the treatment of COVID-19	Yes ☐	No ☐
Patient was treated at home for COVID-19 or suspected COVID-19 and has ongoing respiratory symptoms	Yes ☐	No ☐

If *yes* to either of the above, consider a referral for a full PFT (Spirometry + lung volumes + diffusing capacity/DLCO) 3 months since the onset of COVID-19 infection or discharge from hospital.

Patient was hospitalized or treated at home and has concerning respiratory symptoms at any point in time since the resolution of acute COVID-19	Yes ☐	No ☐

Consider immediate referral for a full PFT (Spirometry + lung volumes + diffusing capacity/DLCO).

This quick reference tool was created with the guidance provided from the Alberta Health Services Medicine Strategic Clinical Network for the use of Pulmonary Function Testing (PFT) following COVID-19 infection.

Documentation of serial lung function decline following COVID-19 infection, even in previously hospitalized asymptomatic patients, could be of value to detect restrictive lung disease. All patients who have had confirmed or suspected COVID-19 infection should be periodically reassessed for the possibility of ongoing respiratory symptoms. Regarding the frequency of follow-up PFT testing in these patients, consider a Respirology Consult.

☐ **Referral for Full PFT**

☐ **Referral for Full PFT & Respirology Consult (please include reference letter)**

CLINIC AND REFERRING PHYSICIAN (PLEASE PRINT OR STAMP)

Referring Physician (please print):_____

Clinic Address (or Clinic Stamp):_____

Date:_____

Signature:_____

Please note some services listed are not covered by Alberta Healthcare.
We will contact the patient to book the appointment.

PATIENT COVID-19 DETAILS & INFORMATION

Covid-19 Infection Date:_____

Symptoms:_____